STATE HEALTH BENEFIT PLAN

UPDATER

Georgia Department of Community Health *October 1, 2001*

Deadlines to File Claims

Providers file claims for you when they participate in a State Health Benefit Plan (SHBP) participating network – such as the MRN/Georgia 1st, Beech Street, Participating Physicians Program, or Express Scripts networks. However, when a provider is not in a participating network, you are responsible for filing a claim within the time limit set by the SHBP. This time limit is currently one year from the date of service, but will be shortened to six months as described below.

For claims related to services received or items purchased (such as prescription drugs) on or after January 1, 2002, Standard PPO, PPO Choice, and High Option members will have six months to file their claims in order to receive SHBP coverage. The six-month period begins the month after you receive a service or purchase an item, including prescription drugs. However, when the SHBP is secondary to another group plan or Medicare, the SHBP allows extra filing time since you will have to wait for an Explanation of Benefits form from your primary plan before you can file with the SHBP. Due to the added wait time, you will have up to twelve months following the month you receive the service or purchase the item to file your secondary claim with the SHBP. If your claim is received after these deadlines, the SHBP will deny your claim.

Although a non-participating provider may file a claim on your behalf as a courtesy, members using non-participating providers remain responsible for ensuring that the SHBP receives the claim by the deadline. If you rely on a non-participating provider to file your claim and the claim is received late, your claim will be denied.

To make the transition to the new timely filing limit, please note the following:

- For claims on prescription drug purchases made from July 1, 2001 through December 31, 2001, Express Scripts will process those claims if they are received within one year from the date of purchase. If the claim is received by Express Scripts after the 12-month deadline, the SHBP will deny the claim. (See the July 1, 2001 UPDATER for additional details about filing prescription drug claims.)
- For claims that are not related to prescription drugs and that are for services received or items purchased on or before December 31, 2001, BlueCross BlueShield of Georgia (BCBS) will process those claims if they are received within one year of the date of service or purchase. If the claim is received by BCBS after the 12-month deadline, the SHBP will deny the claim.
- Claims for services received or items purchased after December 31, 2001 must be filed within six months following the month in which the service or item was received or purchased, unless the SHBP is secondary to another group coverage or Medicare.

Co-payments and PPO Office Visit Charges

The following information is presented to help clarify how your claims are processed:

Co-payments are fixed dollar amounts that must be paid by the member for a particular service or item, for example, $20 for office visits (PPO options) or $60 for emergency room services (PPO and High options). Unless noted otherwise, co-payments are not applied toward deductibles or out-of-pocket spending/stop-loss limits. Most providers collect co-payments at the time of service.

Note for retirees with primary coverage through Medicare: In-network PPO providers may collect the $20 office visit co-payment at the time of service. However, to avoid the possibility of an overpayment from Medicare and the SHBP, some providers may decide not to collect the office visit co-payment.

Also, when a PPO Option member has a covered preventive care office visit with an in-network provider, the eligible office visit charge (minus the $20 co-payment) is applied to the $500 per person, per year wellness benefit. For example, if the Plan's allowed amount for the office visit is $60, you would pay the $20 co-payment and the Plan would pay $40 to the provider and then apply the $40 toward the patient's $500 wellness benefit. Charges for covered lab work and tests associated with the preventive care office visit also apply to the $500 limit. Once the limit is reached, you are responsible for the full cost of related charges for the remainder of the Plan year. Remember, the $500 wellness benefit is not subject to the general deductible.

For PPO Option Members

Services Received at Approved Urgent Care Centers

The following information is presented to help clarify how your claims are processed:

When you receive urgent care (also referred to as "acute care") at an approved urgent care center, all eligible charges are covered at 100% after a $35 co-payment. However, if you go to an approved urgent care center and receive non-urgent care, only the office visit charges are covered at 100% after the $35 co-payment; eligible charges associated with the non-urgent office visit (lab, x-rays, etc.) are covered at 90% of the network rate after meeting the deductible. Urgent/acute care is care provided when such services are medically necessary and immediately required as a result of a sudden onset of illness or injury.

This UPDATER constitutes official notification to State Health Benefit Plan (SHBP) members of Plan changes and, as such, supersedes any previously published information that conflicts with the material included in this UPDATER. Please keep this UPDATER with your Plan documents for future reference. It will be used in conjunction with the SHBP booklet dated November 1, 1995, the HMO Member Handbook dated March 1998, plus any UPDATER published after November 1, 1995,* to administer the Plan until new booklets are published. If you are disabled and need this information in an alternative format, call TDD Relay Service at 800-255-0056 (text telephone) or 800-255-0135 (voice) or write the SHBP at P.O. Box 38342, Atlanta, GA 30334.

***This is the thirteenth UPDATER published since the SHBP booklet dated November 1, 1995.**

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IMPORTANT BENEFIT INFORMATION